IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY
also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as
ROYAL PHARMACY OF CASTLE HILLS and
DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR THE INTERNATIONAL UNION, UAW, and the AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS AMICI CURIAE

JOHN A. FILLION
General Counsel
M. JAY WHITMAN
Assoc. General Counsel
International Union, UAW
8000 E. Jefferson Ave.
Detroit, Michigan 48214

J. ALBERT WOLL
General Counsel
LAWRENCE GOLD
Special Counsel
AFL-CIO
815 16th St., N.W.
Washington, D.C. 20006

THOMAS E. KAUPER, ESQ.
970-A Legal Research Bldg.
Ann Arbor, Michigan 48109
Attorney for UAW and AFL-CIO

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

TABLE OF CONTENTS

INDEX OF AUTHORITIES

INDEX OF AUTHORITIES—Continued

IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY
also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as
ROYAL PHARMACY OF CASTLE HILLS and
DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF FOR THE INTERNATIONAL UNION, UAW, and the AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS AMICI CURIAE

The filing of this brief as *amici curiae*, in support of Petitioners, has been consented to by all the parties under Rule 42(2) of this Court.[1]

---

[1] *See:* Letter to Mr. Rodak, dated April 10, 1978, from counsel for petitioners and respondents.

QUESTION PRESENTED

Does "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), include "participating agreements," *i.e.*, direct contractual arrangements between an insurer and third party provider to supply benefits owed to the insurer's policy holders, where such arrangements are required by the insurance policy.

INTEREST OF AMICI

The UAW is an industrial union representing about 1.4 million workers, and their families, in the automobile, agricultural implement, aerospace, and other industries.

The AFL-CIO is a federation of 109 national and international unions, having a total membership of approximately 14 million workers.

The UAW and the AFL-CIO have pioneered the development of fringe benefit programs, particularly in the health care area. In fact, the prescription drug program at issue here, including its relevant details, was taken directly from the drug program "invented" by the UAW and Ford Motor Company in the 1967 labor negotiations.[2] In 1967-1968 negotiations, this drug program, or one very much like it, was implemented in most of the automobile, agricultural implement, and aerospace industry. It has subsequently been extended to major segments of American industry.[3] This case threatens to unsettle drug programs currently protecting millions of workers and their families.

[2] Goldberg & Loren, *The UAW Negotiated Prepaid Prescription Drug Program*, NS12 J. Am. Pharm. Assn., 422-425 (1972). The reimbursement formula, and the requirement of "participating agreements" were agreed to in the UAW/Ford negotiations. Insurers were asked to supply coverage meeting those specifications.

[3] By 1971, the Rubber Workers, Amalgamated Meatcutters, Retail Clerks, and Teamsters had negotiated a similar drug program with employers. *Id.* at 423, 425. *See also:* Council on Wage and Price Stability, *Employee Health Care Benefits; Labor Management Innovations in Controlling Cost*, 41 Fed. Reg. 40299, 40395 (Sept. 17, 1976).

Respondents' attack is directed against the "participating agreement," the very feature of these programs designed to protect against the rising cost of health care benefits. Such an attack imperils a wide range of benefit programs, not just those covering prescription drugs. The "participating agreement" provides this protection, as well, in negotiated hospital, vision care, hearing aid, physician services, and dental plans. In the auto industry, for example, the use of "participating agreements" is very widespread, if not universal, in hospital, vision care, and hearing aid programs. They are least used in the dental program, but, even there, almost one-half of the beneficiaries of the GMC, Ford, and Chrysler dental programs are in states using "participating" dental agreements. The expanding area of group legal services may be expected to rely heavily on "participating" agreements.

"Participating agreements" play such a central role because, under state regulation, they have been effective. UAW analysis of national data *for 1975*, for the GMC-UAW drug plan puts the average total cost, to plan and participant, of a prescription billed by a *participating* pharmacy at *no more than $6.23*. The average total cost of prescriptions filled, in that year, at *non-participating* pharmacies within a worker's or retiree's area was *$10.63*. In *1976*, the most recent available year, the comparable costs were *$6.64* for a prescription from a *participating* pharmacy, compared to *$11.98* from a *non-participating* pharmacy. Data for the Ford and Chrysler drug programs, by UAW calculations, reveal similar cost differences.

These benefit programs, with their attendant "participating" agreements, are not unique to Blue-Cross/Blue Shield. Employers and unions have implemented

these programs, on the negotiated terms, through a wide range of carriers, varying from state to state and program to program, even with a single employer and union.

SUMMARY OF ARGUMENT

The complaint in this action asserts that the Pharmacy Agreement entered into between Blue Shield of Texas and "participating pharmacies" pursuant to Blue Shield's prepaid prescription drug program is in violation of the Sherman Act. The sole question decided by the Court of Appeals, and now before the Court, is whether the Pharmacy Agreement is part of the "business of insurance" within the meaning of the McCarran-Ferguson Act ("McCarran Act"), which makes the Sherman Act inapplicable to the "business of insurance" to the extent that business is regulated by state law, except in cases of "boycott, coercion, or intimidation."[4] On its face, this is a narrow question. A decision in favor of respondents will not necessarily result in a finding of antitrust liability. The merits of the substantive antitrust claim have not yet been addressed by the courts below. Conversely, a decision in favor of the petitioners, *i.e.*, a holding that the Pharmacy Agreement is part of the "business of insurance," will not in itself render the antitrust

---

[4] The Court of Appeals decision was based solely on its determination that the activities challenged by respondents do not constitute the "business of insurance," which, in its words "obviates the necessity" for determining whether the activities were regulated by state law or were acts of "boycott, coericon, or intimidation." (556 F.2d at 1379, n.3). Although the court's opinion discusses state regulation, it does so in determining only the "business of insurance" issue. While the opinion also refers to the challenged activities as "economically coercive," it does so only in conclusory terms and without purporting to hold that the McCarran Act's exemption is inapplicable for that reason.

The opinion of the Court of Appeals persistently refers to the challenged activities as "price fixing." The substantive antitrust issue, however, was not before the court. Indeed, there has as yet been no discovery on the merits of the antitrust claim.

laws inapplicable. The Pharmacy Agreement might thereafter be held outside the scope of the McCarran Act on either of the two issues the Court of Appeals found unnecessary to reach, namely, that the Agreement was not regulated by state law, or was a form of "boycott, coercion, or intimidation."

While the issue now before the Court is not dispositive, its resolution in favor of the petitioners is of critical import to the continuing efforts of employers, unions, insurers, government bodies and a variety of others to control the rapidly escalating costs of health care, an escalation attributable in significant part to the pervasive impact of health insurance itself. Innovative efforts to utilize the health insurance mechanism to control the escalating costs of health care, and to reduce the impact which health insurance has with respect to these costs, are now underway under the continuing supervision of state regulation. Such efforts will be significantly retarded if, either by virtue of their very purpose—to control health care costs, or by virtue of the utilization of contracts between insurers and third party providers, these actions are not deemed to be part of the "business of insurance" within the meaning of the McCarran Act. Insurers, unions, management and others whose efforts to control costs are met by the hazards and uncertainties of antitrust actions, even in the face of state approval, will be reluctant to proceed. In addition, the federalization of these issues, which the interpretation of the Act urged by respondents will bring about, may itself serve as a deterrent to experimentation, and is inconsistent with the broad policy of the Act to leave the primary responsibility for the regulation of insurance to the states.

Recognition that the "business of insurance" encompasses cost-control programs of the type at issue here neither leaves the health care industry without adequate

competitive safeguards nor completely immunizes conduct of health insurers. The Act's antitrust exemption is conditioned upon a showing that the activities at issue are regulated by state law. The state may take whatever actions it deems necessary to correct what it views as anti-competitive practices. Also, practices properly characterized as acts of "boycott, coercion, or intimidation" are not exempt under the Act in any event. Finally, and perhaps most important, it is not in the economic interest of either the insurer or those whom it insures to engage in practices the effect of which is to create monopoly power in those who provide the very services for which they must pay. The self-interest of insured and their insurers is clearly in a competitive health care industry. They are not likely to act to the contrary.

ARGUMENT

The escalation of health care costs in recent times is a well known phenomenon. Over the last decade, the rise in such costs has far outstripped the rate of inflation in the economy as a whole. Expenditures for health care have more than tripled since 1965,[5] soaring from $39 billion in 1965 to almost $140 billion in 1976.[6] From 1975 to 1976 alone, the increase was more than $17 billion. In 1976, health care represented 8.6 percent of the Gross National Product, and it is now predicted that this figure will climb to 10 percent by the early 1980's.[7] Concern over the impact of these increasing costs on the consumer has risen as the costs themselves have risen. Unions and others negotiating health care benefits on behalf of groups of insureds are particularly concerned, as it

[5] All dates are fiscal years ending July 31.

[6] Gibson and Mueller, *National Health Expenditures, Fiscal Year 1976*, 40 *Social Security Bull No. 4*, (April, 1977) at 4.

[7] Council on Wage and Price Stability, Executive Office of the President, *The Problem of Rising Health Care Costs* 9 (1976).

becomes apparent that these increases make greater inroads on amounts otherwise available for wages or other benefits. As a result, labor unions, and the UAW in particular, continually seek ways to slow down the rise in health care costs.

A number of factors contribute to the dramatic rise in the costs of health care. As medical science progresses, medical advances become more technologically complex and more expensive. But a significant part of the cause of escalating costs is the peculiar nature of the health care industry, which differs in several respects from most industry. A major portion of the health care costs are paid not by those incurring such costs but by third parties, primarily insurers. Additionally, the provider of care, the physician, hospital, or dentist, determines the extent of demand. As a result, the usual pressures to minimize costs are reduced.

The health care industry is characterized by a system of third-party payments to providers on behalf of consumers. The third-party payers range from the government, through such programs as Medicare and Medicaid, to private insurers. In 1976, such third-party payments constituted 68 percent of total expenditures for personal health care.[8] Rising health insurance premiums, then, are the primary medium through which the consumer directly experiences the overall rise in the cost of health care. However, approximately 80 percent of health insurance premiums are paid through employment-related group insurance plans. Only 17.5 percent of these premiums are paid directly by individuals,[9] who may not be conscious of actual premium cost. In any event, at the time of any given medical need, the consumer is unaware of how to translate the specific cost to his in-

[8] *Supra* note 6, at 8.

[9] *Supra* note 7, at 5.

surance premium, and is inclined, if fully insured, to view the service or product as "free."

Unlike most industries, demand for health care services is determined not by the consumers of those services, but by the providers themselves. The physician, hospital, or dentist in most instances determines both the need for care and the extent and nature of the care. The consumer is often neither equipped nor inclined to buy more or less, or to shop to meet his needs.

Incentive to reduce costs in the health care industry is therefore minimized. The predominant incentives are in the direction of providing a greater quantity of service, rather than toward efficiency and cost reduction. With the rapid escalation of costs, cost control measures designed to deal with these inadequacies in the health care industry are being sought. With health insurance itself a significant cause of cost escalation, attention is focusing on utilization of that same mechanism as a means of cost containment. The prescription drug program, with its implementing participating pharmacy agreements, challenged by respondents, is but one example of the means being utilized.

The challenged program derived from the prescription drug program contained in the 1967 collective bargaining agreements between the UAW and domestic automobile manufacturers, a program which remains in current agreements. Continuing effort by the UAW to dampen the escalation of health care costs, through the prescription drug program, reflects the simple fact that every dollar spent by an employer for employee health care benefits comprises money diverted from wages and other benefits. Because of the dramatic increases in health care costs, a substantial part of the increases in

creasing health insurance premium benefits for which the Union has already bargained.[10] The Union is thus pressed to contain health care costs, and plays a major role in the development of health insurance plans consistent with this purpose. These efforts will be severely jeopardized by a determination that the program here attacked by respondents, based upon the very plan contained in the Union's own collective bargaining agreements, does not constitute the "business of insurance."

I.

The Decision of the Court of Appeals Fails To Recognize the Interest of Insurers and Insureds in Containing Health Care Costs And Is Contrary to this Court's Definition of the Term "Business of Insurance."

The Pharmacy Agreements with "participating pharmacies" here at issue were entered into pursuant to the prepaid prescription drug insurance policy approved by the Texas Commissioner of Insurance in 1974. The court below concluded that the Agreements, while "somewhat related" to the business of insurance, are not part of the business because the "relationship . . . is so attenuated." Specifically, the court held that under the standards established in *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the Agreements do not relate directly to the relationship between the insurer and its insured, who "are basically unconcerned with the contract between the insurer and the Participating Pharmacy." (556 F.2d at 1381). It would appear, therefore, that any agreement

---

[10] *See* Hospital Cost Containment Act of 1977: Hearings on S. 1391 Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources, 95th Cong. 1st Sess. 219 (1977) (statement of Douglas A. Fraser, President, UAW). The cost of negotiated health care benefits for the automobile companies now exceeds one dollar per hour per employee. *Id.* at 645 (statement by Chrysler Corporation).

by an insurer to directly contract with and pay the provider, for the delivery of goods or services to insureds, in which the insurer sets the price it will pay, would not satisfy the "business of insurance" requirements of the McCarran Act, as interpreted by the Court of Appeals.

The scope of this holding may be illustrated by the alternatives available to insurers suggested by the court below. The Court of Appeals stated that the insurer's "sole obligation" is to assure that the insureds receive prescription drugs at no more cost than the drug deductible established by the policy. Presumably this obligation could be met by reimbursement of the insureds based upon the actual price paid by them, whatever that might be.[11] While this would assure that insureds did receive drugs without additional expense, it would leave the insurer in the undesirable position of insuring against risks with considerable uncertainty over its costs, and would in no way contribute to the control of costs of the insurer or of health care generally. To the extent the insured desires a policy which would minimize its costs, such an approach is unsatisfactory. Conversely, an insurer presumably could, as part of the "business of insurance," issue a policy which simply reimbursed at a fixed rate for each drug prescribed, without regard to the price actually paid by the insured. While this plan might meet a traditional standard of "insurance," and contribute to the control of the costs of the insurer and of health care generally, it would not satisfy the desire of

[11] In theory, this obligation could also be met if the policy called for reimbursement for drugs purchased only at pharmacies designated by the insurer, such pharmacies being selected for designation on the basis of a history of relatively low retail prices. If no contractual arrangements with providers existed, the rationale of the Court of Appeals might result in a conclusion that such a program was the "business of insurance," even though the economic impact on non-designated pharmacies might be the same as that alleged in respondent's complaint.

insureds to be insured against the risk of all drug expenses incurred as a result of illness. It would not satisfy the contractual policy requirements in the present case.

The Court of Appeals thus conceived the "business of insurance" as involving cash reimbursement of some or all of the expenses incurred when the risk insured against by the policy occurs. Where the insurer provides products and services the insurer has thus entered a different business, which can no longer be characterized as the "business of insurance." This misconceives the nature of the insurance business and the nature of the insurance obligation undertaken by the insurer in the present case. It fails to give adequate weight to the concern of both the insurer and insureds in containment of health care costs. And the court confused the substantive question of competitive effect with the initial "business of insurance" issue, suggesting that because there is an alleged anticompetitive effect outside the insurance business, the acts of the insurer are not the "business of insurance."

Insurance involves the "underwriting of risks" in exchange for a payment by the insured. See *SEC* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 72 (1959). In broad terms, health insurance in various forms insures against the risk of financial loss incurred in the treatment of illness and the attendant risk that the insured will be unable to obtain treatment because of financial inability. The prescription drug policy here at issue is but a specific example. The risk which the insurer underwrites is the risk of financial loss arising from the need to purchase prescribed drugs, and the possibility that such drugs might not be available as the result of financial inability to pay for them. The underlying policy obligates the insurer to enter into participating pharmacy agreements to assure the availability of drugs to its insured at no more than the $2.00 drug deductible charge. Such availability is one way in which the insurer meets

its obligations to underwrite the very risk which it has contractually undertaken through the policy. Whether that risk is satisfied through cash reimbursement, as in the case where a prescription is presented to a non-participating pharmacy, or through participating pharmacy agreements, the fact remains that the insurer has underwritten a specific risk on the basis of a premium paid, and is thus engaged in the "business of insurance." The fact that the insured *could* write a policy meeting the risk needs of its insureds in some other fashion is not a basis for concluding that its present decision is not the "business of insurance." Indeed, one of the critical business judgments within the insurance business is resolution of the very question of how the claims of insureds shall be satisfied. This is a judgment to be arrived at between the insurer and the insureds. It directly involves their relationship, and is thus a critical element of the "business of insurance." See *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969). How the insurer and insureds resolve this issue does not make the business involved something other than insurance.[12]

Recognition of the interest of both insurers and their insureds in effectively containing the costs of health care generally, and health insurance in particular, is central for resolution of the issue before the Court. The insurer desires to contain its costs to remain competitive with other insurers. The insureds, whose premiums directly reflect medical care costs, have an obvious interest, as already noted. The insurance policy between the two, both in terms of basic coverage and the means of satisfying the claimant once the risk insured against has occurred, will reflect the desire of both to contain costs. The insurer, who is ultimately in the business of meeting

[12] These arguments are advanced in more detail by petitioners, and are therefore made in summary fashion here.

the risk underwriting needs of its customers, the insureds, for a price must satisfy those needs. To the extent that insureds desire cost containment measures of the type here involved, the insurer must be in a position to meet those needs. As already indicated, unions and other groups acting on behalf of their members do have a direct concern with cost containment, and have worked directly with insurers to develop programs within the framework of health insurance to develop effective cost control methods.

The Court of Appeals, however, did not consider cost containment to be a goal of any significance to the question before it. It suggested that the insurer's desire to "protect itself and its customers" from rising costs "does not transform the Pharmacy Agreement into the business of insurance," and that the "best way for the firm to protect itself from rising costs is to establish and periodically adjust its rate structure to reflect the impact of inflation." (556 F.2d at 1382). Adjustment of rates may be difficult if rates themselves are directly regulated, but more important, such adjustment would do nothing to contain costs, either to the insurer, its insureds, or the public generally. Indeed, a series of automatic rate adjustments would simply assure that escalating costs are passed on to the ultimate consumer.

The desire of Blue Shield, and other insurers, to devise insurance plans which contribute to cost containment cannot be so cavalierly dismissed. The insurer's business is to meet the desires of its insureds, and to the extent the insureds seek both full cost coverage and lower insurance rates through direct provision of services, utilizing third-party contracts of the type at issue here, satisfying those desires is a direct and integral part of the "business of insurance" and cannot be divorced from it. This is not transformation of the participating pharmacy agreements into something they are not, but recognition of their cen-

tral role in the relationship between the insurer and its insureds, as well as in the determination of rates, as central features of the "business of insurance."

Of course, not every act done by an insurer to reduce its costs must be regarded as part of the "business of insurance," even though all cost reduction may benefit the insureds indirectly through the premium rates set by the insurer.[13] But where the insurer acts to contain the costs of the very services and products whose purchase is the risk underwritten, control of those costs cannot functionally be viewed as separate from the insurance obligation itself.

II.

A Determination that Petitioners' Activities Do Not Constitute the "Business of Insurance" Will Significantly Impair Development of Prepaid Health Care and Health Insurance Plans Utilizing Third-Party Providers, and Insurance Programs Designed to Contain Health Care Costs.

A decision that the challenged Pharmacy Agreements between the insurer and "participating pharmacies" are

[13] If the actions taken by the insurer are not in fact an attempt to control costs, but are instead simply a capitulation to a cartel of providers who by virtue of their bargaining power can impose their own will on the insurer, the actions may not truly be the "business of insurance" at all. The result of such a cartel would be enhancement of the costs of goods and services contrary to the interests of the insurer and its insureds, and would not be part of their direct insurance relationship. *Compare Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36 (1978), where in holding that so-called vertical territorial restrictions imposed by manufacturers on their distributors were not a *per se* violation of the Sherman Act, the Court noted that if such restrictions originated in a cartel of the distributors themselves, the conduct would constitute a *per se* violation. Conversely, if the "participating pharmacy" agreements at issue here are held the "business of insurance" by the insurer, it would be anomolous to hold third parties who did no more than sign such agreements outside the scope of the McCarran-Ferguson Act exemption. This issue is discussed in detail by petitioners.

not an integral part of the "business of insurance," and thus outside the McCarran Act's antitrust exemption will significantly retard the development of a variety of prepaid health care and health insurance plans which, like the program at issue here, involve the use of third-party providers, and will seriously impair the utilization of the health insurance mechanism to control health care costs. The constant threat of antitrust litigation will chill enthusiasm for such programs. And the federalization of these issues which will result will deprive the states of the regulatory flexibility needed to encourage such innovative efforts.

Full application of the antitrust laws to health insurance activities involving third-party providers poses the threat of treble damage liability which may be imposed in private antitrust litigation if the challenged conduct in fact violates those laws. Pending case-by-case determination, the manner in which the antitrust laws apply to such programs is highly uncertain. One need only compare the opinion of the court below, which persistently characterized the insurer's conduct as price fixing, with the views of the Justice Department's Antitrust Division,[14] which concluded that it would not challenge a prepaid prescription similar to the program here at issue, to perceive the uncertainty which exists. Further, the active supervisory and regulatory role played by the states compounds the issue of antitrust liability. Whether conduct by health insurers violates the antitrust laws rests not only upon application of traditional substantive

[14] Business Review Letter from Assistant Attorney General Donald Turner to Gerald R. Goodell, Esq., dated January 15, 1968. (App. B. Amicus Curiae Brief of Blue Shield Association in Support of the Petition for Certiorari).

antitrust standards, but also on an assessment of the pervasiveness and nature of state regulation.[15]

The range of factors potentially affected by application of the antitrust standards is itself great. At issue in the present proceeding is the liability not only of Blue Shield, the insurer, but of those providers who signed the participating pharmacy agreements.[16] Health insurance plans may also be the result of collaboration between the insurers and their insureds, or may be derived from collective bargaining agreements. Unions, management, and other groups of insureds who contribute to the formulation of health care plans may perceive a risk that they may be held to have combined or conspired with the insurers,[17] and thus are directly subject to antitrust

[15] The Court of Appeal's opinion suggested that if the McCarran Act exemption is inapplicable to the challenged activities, the antitrust laws are fully applicable (556 F.2d, at 1380). However, the question of antitrust liability where the appropriate state regulatory authority has mandated, approved, encouraged or otherwise participated in these activities would still presumably be governed by the standards contained in this Court's opinion in *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579 (1976).

[16] The Court of Appeals concluded that petitioner pharmacies are not within the McCarran Act, but its rationale is not clear. If the court only means that the pharmacists who signed the Pharmacy Agreements are not exempt because the activities themselves are not exempt, the ruling simply makes the exemption question the same for all petitioners. If, however, the court means that the pharmacies are not exempt even if the use of such agreements by Blue Shield is the "business of insurance," the inability of direct providers to participate will itself deter, or eliminate, plans of this type. The independent liability of the pharmacists is discussed in detail by Petitioners.

[17] In *Ackerman-Chillingworth, Division of Marsh & McLennan, Inc.* v. *Pacific Electrical Contractors Ass'n.*, —— F.2d —— (9th Cir. 1978), 76 DLR D-1, suit was filed against, *inter alia*, union and management associations challenging as a boycott in violation of the Sherman Act a union-management agreement to handle workmen's compensation insurance through a single group plan, to the exclusion of plaintiff insurance agent and others. The court affirmed a summary judgment in defendants' favor on the merits,

liabiilty in suits filed by disaffected third parties. Finally, a large number of private plaintiffs, providers who are not participants in particular plans or who find the terms on which they are permitted to participate unsatisfactory, as appears to be the situation in the present case, will find the threat of antitrust litigation in their interest. Because the markets in which they operate tend to be local in nature, and because the health care plans as implemented may vary significantly from state to state, a given insurer and other potential defendants face the risk of a large number of relatively localized suits, with varying results.

Irrespective of the outcome on the merits, the threat of private antitrust litigation, with its attendant costs, delays and potential dollar liability exposure, will thus deter from involvement at least some of those whose cooperation is essential to the development or implementation of third-party provider health care plans or other insurance plans seeking to contain costs, at the very time escalation of health care costs are of major national concern. Even if insurers are satisfied that their actions do not run afoul of the antitrust laws, insureds and third-party providers, whose contributions are essential, may perceive their risks differently and decline to participate. Activities necessarily involving a large number of participants for success are peculiarly vulnerable to the threat of antitrust litigation.

Active participation by state regulatory bodies, a past source of stimulus to innovation, may also be frustrated should the Court affirm the narrow interpretation of "business of insurance" adopted by the Court of Appeals.

with one judge dissenting except as to certain insurance company defendants. It did not reach the McCarran Act exemption and the labor exemption, issues which had been raised. Where the challenged program is the result of collective bargaining, the labor exemption may provide some protection to unions and management.

Presumably, the state and its agencies will not be the subject of antitrust liability however the "business of insurance" is resolved. *Parker* v. *Brown*, 317 U.S. 341 (1943). But the ability of these agencies to secure cooperative responses from insurers to regulatory initiatives will depend on the insurers' assessment of the risks of doing so. Caught between regulatory desires and the risk of potential antitrust liability, insurers may conclude that the latter risks are simply too great. Third-party providers and insureds may decline cooperation for the same reason.

The McCarran Act places primary responsibility for the regulation of insurance in the states. *See Prudential Ins. Co.* v. *Benjamin*, 328 U.S. 408, 429-430 (1946). The Act's antitrust exemption is but one aspect of this broader purpose. The federalization of standards, which would necessarily result from the construction of "business of insurance" adopted by the Court of Appeals, will subject the states to a series of constraints impairing the effectiveness of their regulatory authority, contrary to this broad purpose. A state may conclude that federal antitrust laws *should* be applicable to a particular activity of the insurance industry. If so, the states may as a practical matter subject such an activity to the antitrust laws by not regulating it. The narrow reading of "business of insurance" urged by respondents would deprive the states of this election with respect, at least, to third-party providers, and instead make federal antitrust standards mandatory, depriving the states of regulatory flexibility in devising and supervising a variety of means of providing health care services at reasonable cost.

The flexibility of the state regulatory process, and the variant patterns of regulation and state interests from state to state, have permitted a range of experimentation with innovative prepaid health care plans and health in-

surance programs involving third-party providers. Consider, for example, the role played by the state in the insurance program involving third-party providers held to be within the McCarran Act in *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania*, 481 F. 2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973). Imposition of a single, federal antitrust standard will threaten conformity, and tend to stifle such innovative efforts.

Application of federal antitrust standards to provider agreements entered into pursuant to health insurance policies, including prescription drug policies, bifurcates the regulatory process. If a state regulatory body concludes that regulation of the agreements is an essential element to regulation of the policy, or of rates to be charged, imposition of a single federal standard to part, but not all, of what the state deems a single, interrelated set of transactions will jeopardize its ability to deal comprehensively with the issues as a whole. Thus, while interpretation of the statutory phrase "business of insurance" is a question of federal law, the views of the appropriate state regulatory agency that a particular activity is so directly related to the insurance process as to constitute the "business of insurance" is entitled to considerable weight. *See SEC* v. *Variable Annuity Co.*, 359 U.S. 65, 65 (1959). Whether the Texas State Board of Insurance and Attorney General have viewed the provider agreements challenged by respondents as part of the "business of insurance" is disputed, but they appear to have done so. The exertion of regulatory supervision over the prescription drug policy and implementing provider agreements by the Texas Commissioner rests on the direct relationship between them, and is a significant factor in resolving the issue.

III.

Interpretation of the McCarran Act's "Business of Insurance" Requirement To Encompass The Challenged Activities Is Not Inconsistent With the Preservation of Competition in Health Care Provider Markets.

As this Court has said, "competition is our fundamental national economic policy . . ." *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 372 (1963). Exemptions from the antitrust laws, which reflect that policy, are not therefore lightly implied. *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 218 (1966). Specific exemptions are to be construed in light of a presumed Congressional intent to reserve competition where possible, consistent with the overall intent of the exemption. Relevant to the construction of any antitrust exemption, therefore, is the extent to which adequate safeguards against anti-competitive conduct will remain even if the challenged activities fall within the reach of the exemption.

A determination that the activities of respondents challenged here are within the McCarren Act's definition of the "business of insurance" will not leave insurers, providers or others free to engage in anti-competitive conduct which significantly restrains competition in health care markets, the concern of the Court of Appeals. The Act's exemption is not absolute. Conduct which takes the form of "boycott, coercion or intimidation" is expressly excerpted from the exemption, and is thereby directly subject to the antitrust laws even where the "business of insurance" standard is met.[18] Whatever the nature of the challenged activities, the exemption is applicable only

---

[18] The meaning of the "boycott" exception is at this writing before the Court in *St. Paul Fire & Marine Insurance Co.* v. *Barry*, No. 77-240, October 1977 Term, and will not be addressed here.

to the extent the insurance business is regulated by state law. Consistent with the broad purpose of the McCarran Act to place primary responsibility for the regulation of insurance in the states, the states have both the authority and responsibility to deal with anti-competitive conduct inconsistent with their own regulatory schemes. A state may deal with such conduct through its regulatory process, or could elect to rely on the provisions of its own antitrust law should it find that appropriate. Indeed, by simply not regulating the activities in question, the state, as a practical matter, could make the conscious determination to rely on the federal antitrust laws. The states are thus hardly powerless to act to prevent anti-competitive conduct by insurers and those acting in concert with them.

The ultimate safeguard, however, against conduct by insurers which restrains competition in health care provider markets is self-interest. Not only do the insurers and insured have no economic interest in restraining competition in the very markets where they must purchase, or reimburse purchases, it is contrary to their economic interest to do so. The Court of Appeals characterized the petitioners' activities as a boycott, foreclosing non-participating pharmacies from the market. The competitive danger of such foreclosure is the creation of monopoly power in the participating pharmacies. But the Court of Appeals never questions why the insurer would have any economic interest in the creation of such power. The inevitable consequence would be an increase in the price of prescription drugs, a result hardly in the interest of either the insurer or its insureds. Just as a manufacturer of goods will normally find the creation of monopoly power in those who distribute its goods contrary to its own economic interest, *see Continental T.V. Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 56 (1977), so

too creation of monopoly power in suppliers is against the economic interest of those purchasing from them.[19]

The states have adequate power to deal with any anti-competitive conduct by insurers, providers and others engaged in the "business of insurance." And interpretation of the McCarran Act's "business of insurance" standard to encompass health insurance plans utilizing third-party provider agreements as a means of satisfying the claim of insureds poses no threat of monopoly power in health care provider markets.

CONCLUSION

For the foregoing reasons, we urge the Court to *reverse* the decision of the Fifth Circuit.

Respectfully submitted,

JOHN A. FILLION
General Counsel
M. JAY WHITMAN
Assoc. General Counsel
International Union, UAW
8000 E. Jefferson Ave.
Detroit, Michigan 48214

J. ALBERT WOLL
General Counsel
LAWRENCE GOLD
Special Counsel
AFL-CIO
815 16th St., N.W.
Washington, D.C. 20006

THOMAS E. KAUPER, ESQ.
970-A Legal Research Bldg.
Ann Arbor, Michigan 48109

Attorney for UAW and AFL-CIO

May 12, 1978

---

[19] The creation of monopoly power would be in the interest of health care providers, who might impose a cartel agreement among themselves on an otherwise unwilling insurer with insufficient strength to resist. Such an arrangement can be distinguished from legitimate cost containment measures, *cf. Continental T.V. Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 58 n. 28 (1977), and need not be viewed as the "business of insurance." See note 13 *supra*.